

PUBLIC WATER SYSTEM REPORT

LAB NAME:

ADDRESS:

CITY, STATE, ZIP:

PHONE NUMBER:

CERTIFIED LAB ID NUMBER

Sample Number

Time & Date Received

Date Reported

Samples will not be analyzed if form is not complete. Use black ink.**Laboratory - please send a copy to:**

Name:

Street:

City: IN (Zip)

Organization Phone Number

TO BE COMPLETED BY PUBLIC WATER SYSTEM

PWS ID

County

Date

Time Location Code

Sampling Location Address

Chlorine Residual at Sampling Address mg/l

Printed Name & Initial of Sample Collector

SAMPLE TYPE (check appropriate square)☐ D--Distribution ☐ C--Repeat ☐ O--OtherDate Original Sample Collected
(If sample is a repeat)

REMARKS:

Printed Name & Signature of Certified Operator

ANALYSIS DATA -FOR LAB USE ONLY**TEST: TOTAL COLIFORM****METHOD*:**☐ MF ☐ MPN ☐ LST P/A ☐ MM P/A ☐ MM QT**RESULTS:**

Most Probable Number

☐ PRESENT ☐ ABSENT

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Analyst:

Date:

Time:

TEST: ☐ FECAL COLIFORM ☐ E. COLI**METHOD*:**☐ MF ☐ MPN ☐ LST P/A ☐ MM P/A ☐ MM QT**RESULTS:**

Most Probable Number

☐ PRESENT ☐ ABSENT

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Analyst:

Date:

Time:

HETEROTROPHIC

PLATE COUNT

/1.0ML

/0.1ML

*If MPN or MMQT is checked, the result is a statistical determination of the most probable number per 100ml.
If MF is checked, the result is organisms per 100ml.
If P/A is checked, the result is present or absent.

REPORT OF SAMPLES☐ **SUBMIT REPEAT SAMPLES** as required under 327 IAC 8-2-8.1☐ **PLEASE SUBMIT ANOTHER SAMPLE. TEST NOT VALID BECAUSE:**

- ☐ Too long in transit (more than 48 Hours).
- ☐ Invalid or no collection date and/or time.
- ☐ Sample leaked or broken in shipment, insufficient volume.
- ☐ Residual chlorine present.
- ☐ Other

Approved by:

Reviewed by: